2011-2012 INFLUENZA (INACTIVATED) VACCINE ADMINISTRATION RECORD (VAR)

LAST NAME | FIRST NAME | MI

MAILING ADDRESS

CITY | STATE | ZIP | HOME PHONE

DATE OF BIRTH (M M D D Y Y Y Y) | GENDER (M / F) | AGE | **Anthem ID Number (ex. 123M45678 :**

PRIMARY PHYSICIAN | PHONE | FAX ❑ Date:___/___/___

❑ Yes ❑ No 1. Have you ever had a flu vaccination?

❑ Yes ❑ No 2. Do you have or have you ever had allergies or a serious reaction to vaccines, medications, including neomycin or polymyxin, or food, including eggs or the preservative thimerosal?
If yes, please list: _____

❑ Yes ❑ No 3. Do you have any chronic illnesses?
If yes, please list: _____

❑ Yes ❑ No 4. Do you have a fever or are you feeling ill today?

❑ Yes ❑ No 5. Are you allergic to latex (*Pharmacist – If yes, use Afluria only*)

❑ Yes ❑ No 6. For Men: Do you weigh over 260 pounds? (determines needle length)

❑ Yes ❑ No 7. For Women: Do you weigh over 200 pounds? (determines needle length)

I have read, or had read to me, the written information regarding the vaccine I requested. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine being administered and have received a copy of the Vaccine Information Statement (VIS). I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Kroger Co., Inc., its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine requested. I understand that the information contained on this form may be shared with the State Health Department (SHD) and state immunization registries, and will remain confidential and will not be released without my consent. If eligible, I ask that payment of authorized Medicare benefits be made on my behalf to Kroger Pharmacy for the immunization administered to me by Kroger pharmacy. I am authorizing any holder of medical or other information about myself to be released to Centers for Medicare and Medicaid Services (CMS) and its agents, including any information needed to determine any and all benefits for related services. If Medicare Part B denies payment because a HMO plan is my primary plan then I will be responsible for payment upon denial from one of these payors. **I agree to wait near the vaccination area for approximately 20 minutes to receive treatment in case of adverse reaction.**

SIGNATURE OF PATIENT OR GUARDIAN | DATE

PRINTED NAME OF PATIENT OR GUARDIAN | RELATION TO PATIENT

FOR PHARMACIST USE ONLY

DRUG (ADMINISTRATION FEE INCLUDED)	CLINIC USE	
PLACE APPROPRIATE PHARMACY LABEL HERE VACCINATOR SHOULD SIGN OR INITIAL THIS LABEL	Store #:_____ Manufacturer: _____ Lot #: _____ Expiration Date: _____ Dose: _____0.5mL_____	VIS Date: _____07-26-11_____ Date Administered: _____ Injection Site: IM L or R Deltoid Signature of Vaccinator: _____